Date:	August 20, 2015
To:	Mike Kivitz, Chief Executive Officer
Provider:	Adelante Development Center
Address:	3900 Osuna Rd. NE
State/Zip:	Albuquerque, New Mexico 87109
E-mail Address:	mkivitz@goadelante.org
CC:	Jim Bullard, Vice President
E-Mail Address	jbullard@goadelante.org
CC:	Phil Blackshear, QAO
E-Mail Address	pblackshear@goadelante.org
Region:	Metro
Survey Date:	May 4 – 13, 2015
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2012:*** *Living Supports* (Supported Living and Family Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services) and *Other* (Customized In-Home Supports) ***2007:*** *Community Living* (Supported Living, Family Living, Independent Living) and *Community Inclusion* (Adult Habilitation, Supported Employment)
Survey Type:	Routine
Team Leader:	Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Nicole Brown, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Tony Fragua, BFA, Health Program Manager, Division of Health Improvement/Quality Management Bureau; Crystal Lopez-Beck, BA, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau; Florence Mulheron, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Meg Pell, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Richard Reyes, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Stephanie Roybal, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Corrina Strain, RN, BSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jesus Trujillo, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Kivitz;

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities

Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Determination of Compliance:
The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

Partial Compliance with Conditions of Participation

The following tags are identified as Condition of Participation Level Deficiencies:

- Tag #1A22 Agency Personnel Competency

This determination is based on noncompliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

Plan of Correction:
The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

Submission of your Plan of Correction:
Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. *(See attachment "A" for additional guidance in completing the Plan of Correction)*.

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator 1170 North Solano Suite D Las Cruces, New Mexico 88001**

2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Request for Informal Reconsideration of Findings (IRF):
If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

QMB Deputy Bureau Chief
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition

or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator Amanda Castaneda at 575-373-5716 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Erica Nilsen, BA

Erica Nilsen, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	May 4, 2015
Present:	**Adelante Development Center, Inc.** Reina Chavez, Vice-President of Community Operations **DOH/DHI/QMB** Erica Nilsen, BA, Team Lead/Healthcare Surveyor Meg Pell, BA, Healthcare Surveyor Richard Reyes, BS, Healthcare Surveyor Stephanie Roybal, BA, Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor Jesus Trujillo, RN, Healthcare Surveyor Tony Fragua, BFA, Health Program Manager
Exit Conference Date:	May 12, 2015
Present:	**Adelante Development Center, Inc.** Reina Chavez, Vice-President of Community Operations Andy Vitka, Chief Financial Officer/Vice President of Finance Donna Long, Training Coordinator Phil Blackshear, Quality Assurance Officer Brian Ammerman, Vice President of Business Operations Jim Bullard, Vice President of Management Services Rebecca Sanford, Chief Administrative Officer Melinda Garcia, Director of Family Living, Independent Living and Supported Employment Sharon Coleman, Assistant Vice President Options and Support Services Elona Boelter, Director of Client Services-Living Support Eren-Skye Elliott, Client Services Manager Mary Hemstreet, Director of Client Services-Community Supports Anne Cole, Client Systems Coordinator Kaydee Flanagan, Associate Director of Community Living Mike Kivitz, Chief Executive Officer **DOH/DHI/QMB** Erica Nilsen, BA, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Health Program Manager Crystal Lopez-Beck, Deputy Bureau Chief
Administrative Locations Visited	Number: 1 (3900 Osuna Road NE, Albuquerque New Mexico, 87109; 6911 Taylor Ranch Road NW Suite C-1 C-2, Albuquerque NM 87120; 5400 San Mateo NE, Albuquerque New Mexico, 87109; 3501 Princeton NE, Albuquerque New Mexico, 87107; 1618 1st NW, Albuquerque New Mexico, 87102; 835 Main Street SE Suite 103, Los Lunas New Mexico 87031; 414 East Reiken Avenue, Belen New Mexico, 87002)
Total Sample Size	Number: 55 13 - *Jackson* Class Members 42 - Non-*Jackson* Class Members

		13 - Supported Living 7 - Family Living 12 - Adult Habilitation 2 - Supported Employment 29 - Customized Community Supports 26 – Community Integrated Employment Services 7 - Customized In-Home Supports
Total Homes Visited	Number:	19
❖ Supported Living Homes Visited	Number:	12 *Note: The following Individuals share a SL residence:* ➢ #7, 37
❖ Family Living Homes Visited	Number:	7
Persons Served Records Reviewed	Number:	55
Persons Served Interviewed	Number:	34
Persons Served Observed	Number:	21 (21 Individuals were not available for interviews at time of on-site visit)
Direct Support Personnel Interviewed	Number:	50
Direct Support Personnel Records Reviewed	Number:	254
Substitute Care/Respite Personnel Records Reviewed	Number:	8
Service Coordinator Records Reviewed	Number:	17

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
    - Individual Service Plans
    - Progress on Identified Outcomes
    - Healthcare Plans
    - Medication Administration Records
    - Medical Emergency Response Plans
    - Therapy Evaluations and Plans
    - Healthcare Documentation Regarding Appointments and Required Follow-Up
    - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry

- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
MFEAD – NM Attorney General

Attachment A

Provider Instructions for Completing the QMB Plan of Correction (POC) Process

Introduction:
After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings (Providers who fail to complete a POC within the 45 business days allowed will be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

Instructions for Completing Agency POC:

Required Content
Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your Plan of Correction:

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc.;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

Note: **Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps must be taken to ensure the deficiency is corrected and will not recur.

Completion Dates

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
    a. Electronically at AmandaE.Castaneda@state.nm.us *(preferred method)*
    b. Fax to 575-528-5019, or

c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001

5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been "approved" or "denied."
    a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a ***maximum*** of 45 business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).
3. All submitted documents ***must be annotated***; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
    - Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
    - Copies of "void and adjust" forms submitted to Xerox State Healthcare, LLC to correct all unjustified units identified and submitted for payment during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

Attachment B

Department of Health, Division of Health Improvement
QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Management system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified in the QMB Report of Findings. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Within the QMB Service Domains there are fundamental regulations, standards, or policies with which a provider must be in essential compliance in order to ensure the health and welfare of individuals served known as Conditions of Participation (CoPs).

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in three (3) Service Domains.

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

- Qualified Provider
- Plan of Care
- Health, Welfare and Safety

Conditions of Participation (CoPs)

A CoP is an identified fundamental regulation, standard, or policy with which a provider must be in compliance in order to ensure the health and welfare of individuals served. CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances. A provider must be in compliance with CoPs to participate as a waiver provider.

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP (See the next section for a list of CoPs). The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for

significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

CoPs and Service Domains for Case Management Supports are as follows:

Service Domain: Level of Care

Condition of Participation:

1. **Level of Care**: The Case Manager shall complete all required elements of the Long Term Care Assessment Abstract (LTCAA) to ensure ongoing eligibility for waiver services.

Service Domain: Plan of Care

Condition of Participation:

2. **Individual Service Plan (ISP) Creation and Development**: Each individual shall have an ISP. The ISP shall be developed in accordance with DDSD regulations and standards and is updated at least annually or when warranted by changes in the individual's needs.

Condition of Participation:

3. **ISP Monitoring and Evaluation:** The Case Manager shall ensure the health and welfare of the individual through monitoring the implementation of ISP desired outcomes.

CoPs and Service Domain for ALL Service Providers is as follows:

Service Domain: Qualified Providers

Condition of Participation:

4. **Qualified Providers**: Agencies shall ensure support staff has completed criminal background screening and all mandated trainings as required by the DDSD.

CoPs and Service Domains for Living Supports and Inclusion Supports are as follows:

Service Domain: Plan of Care

Condition of Participation:

5. **ISP Implementation**: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

Service Domain: Health, Welfare and Safety

Condition of Participation:

6. **Individual Health, Safety and Welfare: (Safety)** Individuals have the right to live and work in a safe environment.

Condition of Participation:

7. **Individual Health, Safety and Welfare (Healthcare Oversight)**: The provider shall support individuals to access needed healthcare services in a timely manner. Nursing, healthcare services and healthcare oversight shall be available and provided as needed to address individuals' health, safety and welfare.

QMB Determinations of Compliance

Compliance with Conditions of Participation

The QMB determination of *Compliance with Conditions of Participation* indicates that a provider is in compliance with all Conditions of Participation, (CoP). The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

Partial-Compliance with Conditions of Participation

The QMB determination of *Partial-Compliance with Conditions of Participation* indicates that a provider is out of compliance with Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains.

Providers receiving a repeat determination of Partial-Compliance for repeat deficiencies at the level of a Condition in any Service Domain may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

Non-Compliance with Conditions of Participation

The QMB determination of *Non-Compliance with Conditions of Participation* indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

Providers receiving a repeat determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

Attachment C

Guidelines for the Provider
Informal Reconsideration of Finding (IRF) Process

Introduction:

Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "Administrative Needs," etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: http://dhi.health.state.nm.us/qmb
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Crystal Lopez-Beck at Crystal.Lopez-Beck@state.nm.us for assistance.

The following limitations apply to the IRF process:

- The written request for an IRF and all supporting evidence must be received within 10 business days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the DHI/QMB determination of compliance or the length of their DDSD provider contract.

A Provider forfeits the right to an IRF if the request is not received within 10 business days of receiving the report and/or does not include all supporting documentation or evidence to show compliance with the standards and regulations.

The IRF Committee will review the request, the Provider will be notified in writing of the ruling; no face-to-face meeting will be conducted.

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

Agency: **Adelante Development Center, Inc. – Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** *Living Supports* (Supported Living, Family Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living, Family Living, Independent Living) and *Community Inclusion* (Adult Habilitation, Supported Employment)
Monitoring Type: Routine Survey
Survey Date: **May 4 - 13, 2015**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08 **Agency Case File**	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **Chapter 5 (CIES) 3. Agency Requirements** **H. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. Additional documentation that is required to be maintained at the administrative office includes: 1. Vocational Assessments that are of quality and contain content acceptable to DVR and DDSD; 2. Career Development Plans as incorporated in the ISP; and 3. Documentation of evidence that services provided under the DDW are not otherwise available under the Rehabilitation Act of 1973 (DVR). **Chapter 6 (CCS) 3. Agency Requirements:** **G. Consumer Records Policy:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 32 of 55 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • **ISP budget forms MAD 046** ◦ Not Current (#55) ◦ Not Complete (Only has SL on it) (#42) ◦ Not Current (#6, 11, 13) *(No POC required as budget is delayed due to Third Party Assessor)* • **Current Emergency and Personal Identification Information** ◦ Did not contain Pharmacy Information (#36, 41) ◦ Did not contain Health Plan Information (#7, 10, 12, 22, 24, 25, 32, 33, 36, 41, 44)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. Additional documentation that is required to be maintained at the administrative office includes: 1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD. **Chapter 7 (CIHS) 3. Agency Requirements:** **E. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 11 (FL) 3. Agency Requirements:** **D. Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 12 (SL) 3. Agency Requirements:** **D. Consumer Records Policy:** All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 13 (IMLS) 2. Service Requirements:** C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items) • Emergency contact information; • Personal identification; • ISP budget forms and budget prior authorization;	• Positive Behavioral Support Plan (#13) • Behavior Crisis Intervention Plan (#4, 8, 13, 16, 30, 31, 35, 39) • Speech Therapy Plan (#21, 33, 44) • Occupational Therapy Plan (#20, 21, 27, 44, 54) • Physical Therapy Plan (#27, 28) • Documentation of Guardianship/Power of Attorney (#17, 36, 45) • **Annual Physical** (#32, 35, 44) • **Dental Exam** ° Individual #13 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ° Individual #31 - As indicated by collateral documentation reviewed, exam was completed in 8/2014. Follow-up was to be completed in 6 months. No evidence of follow-up found. ° Individual #33 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ° Individual #36 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.		

• ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan (PBSP), Behavior Crisis Intervention Plan (BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI); • Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least annually, or upon admission for a short term stay; • Copy of Guardianship or Power of Attorney documents as applicable; • Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays; • Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable; • Progress notes written by DSP and nurses; • Signed secondary freedom of choice form; • Transition Plan as applicable for change of provider in past twelve (12) months. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012** **III. Requirement Amendments(s) or Clarifications:** A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.	◦ Individual #44 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #57 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • **Vision Exam** ◦ Individual #5 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #13 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #41 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #44 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #57 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.		

H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation; (4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort			

Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital. **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.			

Tag # 1A08.1 Agency Case File - Progress Notes	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **Chapter 5 (CIES) 3. Agency Requirements: 6. Reimbursement A. 1.** …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 6 (CCS) 3. Agency Requirements: 4. Reimbursement A. Record Requirements 1.** …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 7 (CIHS) 3. Agency Requirements: 4. Reimbursement A. 1.**…Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 11 (FL) 3. Agency Requirements: 4. Reimbursement A. 1.**…Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 12 (SL) 3. Agency Requirements: 2. Reimbursement A. 1…** Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record…	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 6 of 55 Individuals. Review of the Agency individual case files revealed the following items were not found: **Community Integrated Employment Services Progress Notes/Daily Contact Logs** • Individual #4 - None found for 3/31/2015. • Individual #5 - None found for 2/18/2015. • Individual #16 - None found for 1/6, 8, 13, 15, 20, 22, 27, 29; 2/5, 10, 12, 17, 19, 24, 26 and 3/3, 5, 10, 12, 17, 19, 24, 26, 31, 2015. • Individual #44 – None found for 3/13/2015. • Individual #56 – None found for 1/3, 8, 21 and 2/12, 14, 2015. **Customized In Home Supports Progress Notes/Daily Contact Logs** • Individual #47 - None found for 3/23/2015.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Chapter 13 (IMLS) 3. Agency Requirements: 4. Reimbursement A. 1.…Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 15 (ANS) 4. Reimbursement A. 1.** …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (3) Progress notes and other service delivery documentation;			

Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	Standard Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.	Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 10 of 55 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #38 • According to the Live Outcome; Action Step for "…Will care for his garden" is to be completed 3 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2015 - 3/2015. Individual #50 • None found regarding: Live Outcome/Action Step: "Will work on making a latch hook pillow" for 1/2015. • None found regarding: Fun Outcome/Action Step: "Will save a minimum of $2 each week" for 1/2015. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**:	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Individual #10 • No Outcomes or DDSD exemption/decision justification found for Customized Community Supports Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver." Individual #41 • None found regarding Fun Outcome/Action Step: "Wants to be safe at her job" for 1/2015 - 3/2015. **Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #2 • None found regarding: Work/learn #2 Outcome/Action Step: "Will let new mall employees know about his food" for 1/2015 - 3/2015. Individual #16 • None found regarding: Work/learn Outcome/Action Step: "Will prep files 3x per week" for 1/2015 - 3/2015. Individual #27 • According to the Work/Learn Outcome; Action Step for "will work on the cash register" is to be completed 3 times per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2015. Individual #47		

	• According to the Work/Learn Outcome; Action Step for "Will practice the four hourly rated job tasks" is to be completed 1 time per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2015 - 3/2015. **Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #46 • None found regarding Fun Outcome/Action Step: "Will choose and participate in a physical activity in the community" for 1/2015 - 2/2015. Individual #47 • According to the Live Outcome; Action Step for "Will sort his mail" is to be completed 4 times per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2015. • None found regarding Live Outcome/Action Step: "Will shred his junk mail" for 1/2015 - 3/2015. **Residential Files Reviewed:** **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #11 • According to the Live Outcome; Action Step for "Will increase his safety in eating and drinking using concrete strategies" is to be completed 1 time daily, evidence found		

	indicated it was not being completed at the required frequency as indicated in the ISP for 5/1 - 5, 2015.		

Tag # IS11 / 5I11 Reporting Requirements Inclusion Reports	Standard Level Deficiency		
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 3. Agency Requirements:** **I. Reporting Requirements:** The Community Integrated Employment Agency must submit the following: 1. Semi-annual progress reports to the case manager one hundred ninety (190) calendar days following the date of the annual ISP; a. Written updates to the ISP Work/Learn Action Plan annually or as necessary due to change in work goals to the case manager. These updates do not require an	Based on record review, the Agency did not complete written status reports as required for 1 of 53 individuals receiving Inclusion Services. Review of the Agency individual case files revealed the following items were not found, and/or incomplete: **Customized Community Supports Semi-Annual Reports** • Individual #5 - None found for 11/2014 - 4/2015. *(Term of ISP 11/2014 - 11/2015).* **Community Integrated Employment Services Semi-Annual Reports** • Individual #5 - None found for 11/2014 - 4/2015. *(Term of ISP 11/2014 - 11/2015).*	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

IDT meeting unless changes requiring team input need to be made (e.g., adding more hours to the Community Integrated Employment budget); b. Written annual updates to the ISP work/learn action plan to DDSD; 2. VAP to the case manager if completed externally to the ISP; 3. Initial ISP reflecting the Vocational Assessment or the annual ISP with the updated VAP integrated or a copy of an external VAP if one was completed to DDSD; 4. Quarterly Community Integrated Employment Wage and Hour Reports for individuals employed and in job development to DDSD based on the DDSD fiscal year; and a. Data related to the requirements of the Performance Contract to DDSD quarterly. **CHAPTER 6 (CCS) 3. Agency Requirements: H. Reporting Requirements:** The Customized Community Supports Provider Agency shall submit the following: 1. Semi-annual progress reports one hundred ninety (190) days following the date of the annual ISP, and 14 days prior to the annual IDT meeting: a. Identification of and implementation of a Meaningful Day definition for each person served; b. Documentation for each date of service delivery summarizing the following: i. Choice based options offered throughout the day; and			

ii. Progress toward outcomes using age appropriate strategies specified in each individual's action steps in the ISP, and associated support plans/WDSI. c. Record of personally meaningful community inclusion activities; and d. Written updates, to the ISP Work/Learn Action Plan annually or as necessary due to change in work goals. These updates do not require an IDT meeting unless changes requiring team input need to be made. e. Data related to the requirements of the Performance Contract to DDSD quarterly. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and			

(b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP. (3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.			

Tag # LS14 / 6L14 Residential Case File	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 11 (FL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 12 (SL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 13 (IMLS) 2. Service Requirements** **B.1. Documents To Be Maintained In The Home:** a. Current Health Passport generated through the e-CHAT section of the Therap website and printed for use in the home in case of disruption in internet access; b. Personal identification; c. Current ISP with all applicable assessments, teaching and support strategies, and as applicable for the consumer, PBSP, BCIP, MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans (e.g. PRN Psychotropic Medication Plans) as applicable; d. Dated and signed consent to release information forms as applicable; e. Current orders from health care practitioners; f. Documentation and maintenance of accurate medical history in Therap website;	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 20 of 20 Individuals receiving Family Living Services and Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: • **Current Emergency and Personal Identification Information** ◦ None Found (#17) ◦ Did not contain Pharmacy Information (#11, 42, 48) ◦ Did not contain Health Plan Information (#3, 4, 6, 7, 11, 18, 26, 29, 30, 34, 37, 38, 42, 45, 48, 49, 50, 51) • Annual ISP (#14, 29) • ISP Signature Page (#14) • Individual Specific Training Section of ISP (#29) • **ISP Teaching and Support Strategies** ◦ *Individual #3 - TSS not found for the following Action Steps:* ◦ Fun/Relationship Outcome Statement ➢ "Will meet up with and share time with my best friend …. out in the community" at least 24 times during the ISP year. ◦ Live Outcome Statement	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

g. Medication Administration Records for the current month; h. Record of medical and dental appointments for the current year, or during the period of stay for short term stays, including any treatment provided; i. Progress notes written by DSP and nurses; j. Documentation and data collection related to ISP implementation; k. Medicaid card; l. Salud membership card or Medicare card as applicable; and m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012** **III. Requirement Amendments(s) or Clarifications:** A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. ***Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007*** **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a	➢ "Will host themed parties in my home for my friends and family at least 6 times over the next ISP year." ◦ Individual #4 - *TSS not found for the following Action Steps:* ◦ Work/Learn Outcome Statement ➢ "Will sort, bag, and tag jewelry twice each week." ◦ Individual #11 - *TSS not found for the following Action Steps:* ◦ Live Outcome Statement ➢ "Will increase his safety in eating and drinking using concrete strategies daily." ➢ "Will choose new healthy food given a variety of options with the assistance from his SLP" 1 time monthly. ➢ "Will increase his physical activity level (exercise) with the assistance of his FLP" 1 time a week. ◦ Fun/Relationships Outcome Statement ➢ "Will attend an outing of his choice within the community" 1 time quarterly. ◦ Individual #14 - *TSS not found for the following Action Steps:* ◦ Live Outcome Statement ➢ "Will make a card for her family" 1 time a month. ➢ "Will walk to the mail box to mail the card" 1 time a month. ◦ Individual #29 - *TSS not found for the following Action Steps:*		

complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);	◦ Live Outcome Statement ➢ "Will practice communicating directly to cashier at public establishments" 2 times a month. ◦ Individual #30 - *TSS not found for the following Action Steps:* ◦ Live Outcome Statement ➢ "Will choose an exercise he wants to do" 2 times a week. ➢ "Will exercise at least 30 minutes" 2 times a week. ◦ Fun/Relationships Outcome Statement ➢ "Will choose and engage in an activity" 1 time a month. ➢ "Invite friends over for a game night" 4 times a year. ◦ Individual #49 - *TSS not found for the following Action Steps:* ◦ Live Outcome Statement ➢ "With assistance, will practice checking out books at the library monthly." ◦ Individual #50 - *TSS not found for the following Action Steps:* ◦ Live Outcome Statement ➢ "Twice a month, will work on making a latch hook pillow, completing at least one latch hook pillow by the end of the ISP." ◦ Fun/Relationships Outcome Statement ➢ "Will save a minimum of $2 each week, each week for the next year."		

(9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the	◦ Individual #51 - *TSS not found for the following Action Steps:* ◦ Live Outcome Statement ➢ "Will download new apps" 10 times. ➢ "Will experience working with the apps" 10 times • Positive Behavioral Support Plan (#29) • Behavior Crisis Intervention Plan (#4, 30) • Speech Therapy Plan (#3, 38) • Occupational Therapy Plan (#17, 49) • Healthcare Passport (#4, 11, 18, 26, 34, 38, 51) • **Health Care Plans** ◦ Body Mass Index (#50) ◦ Diabetes (#50) ◦ Falls (#50) ◦ Goiter (#50) ◦ Oral Hygiene (#50) ◦ Seizures (#50) • **Medical Emergency Response Plans** ◦ Allergies (#11, 26) ◦ Diabetes (#50) ◦ Gastro-intestinal (#26) ◦ Seizures (#50) • **Progress Notes/Daily Contacts Logs:** ◦ Individual #4 - None found for 5/1/2015. ◦ Individual #6 - None found for 5/1 – 2, 2015.		

developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.	◦ Individual #11 - None found for 5/1 – 5, 2015. ◦ Individual #18 - None found for 5/1 – 3, 2015. ◦ Individual #38 - None found for 5/1/2015 • **Progress Notes written by DSP and/or Nurses regarding Health Status:** ◦ Individual #11 - None found for May 2015. **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #11 • According to the Live Outcome; Action Step for "Will increase his safety in eating and drinking using concrete strategies" is to be completed 1 time daily, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/1 - 5, 2015.		

Tag # IH17 Reporting Requirements (Customized In-Home Supports Reports)	Standard Level Deficiency		
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 7 (CIHS) 3. Agency Requirements: F. Customized In-Home Supports Provider Agency Reporting Requirements:** 1. **Semi-Annual Reports:** Customized In-Home Supports providers must submit written semi-annual status reports to the individual's Case Manager and other IDT members no later than one hundred ninety (190) calendar days after the ISP effective date and fourteen (14) calendar days prior to the annual ISP meeting. When reports are developed in any language other than English, it is the responsibility of the provider to translate the	Based on record review, the Agency did not complete written status reports for 1 of 7 individuals receiving Customized In-Home Supports. Review of the Agency individual case files revealed the following items were not found, and/or incomplete: **Customized In-Home Supports Semi-Annual Reports:** • Individual #43 – None found for 9/2014-3/2015. *(Term of ISP 3/2014 - 3/2015).*	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

reports into English. The semi-annual reports must contain the following written documentation: a. Name of individual and date on each page; b. Timely completion of relevant activities from ISP Action Plans; c. Progress towards desired outcomes in the ISP accomplished during the past six (6) months; d. Significant changes in routine or staffing; e. Unusual or significant life events, including significant change of health condition; f. Data reports as determined by IDT members; and g. Signature of the agency staff responsible for preparing the reports.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A11.1 **Transportation Training**	**Standard Level Deficiency**		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy **Eff. Date:** March 1, 2007 **II. POLICY STATEMENTS:** I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency) **NMAC 7.9.2 F. TRANSPORTATION:**	Based on record review and interview, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 18 of 254 Direct Support Personnel. **No documented evidence was found of the following required training:** • Transportation (DSP #248, 263, 264, 282, 318, 324, 327, 332, 392, 396, 405, 434, 438, 444, 446) **When DSP were asked if they had received transportation training including training on the agency's policies and procedures following was reported:** • DSP #346 stated, "No, I don't transport." • DSP #353 stated, "No, I do not transport." • DSP #401 stated, "No, I do not transport the Individuals."	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

(1) Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training program in passenger transportation assistance before assisting any resident. The passenger transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of equipment, familiarity with state regulations governing the transportation of persons with disabilities, and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed. **(2)** Any employee or agent of a regulated facility or agency who drives a motor vehicle provided by the facility or agency for use in the transportation of clients must complete: **(a)** A state approved training program in passenger assistance and (**b)** A state approved training program in the operation of a motor vehicle to transport clients of a regulated facility or agency. The motor vehicle transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of motor vehicles, familiarity with state regulations governing the transportation of persons with disabilities, maintenance and safety record keeping, training on hazardous driving conditions and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed.			

(c) A valid New Mexico driver's license for the type of vehicle being operated consistent with State of New Mexico requirements. **(3)** Each regulated facility and agency shall establish and enforce written polices (including training) and procedures for employees who provide assistance to clients with boarding or alighting from motor vehicles. **(4)** Each regulated facility and agency shall establish and enforce written polices (including training and procedures for employees who operate motor vehicles to transport clients. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. **CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.** All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy; **CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:** The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the			

DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has			

completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. **CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.** E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;			

Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in	Based on record review, the Agency did not ensure Orientation and Training requirements were met for 54 of 254 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #236, 291, 318, 327, 405, 438, 444) • Foundation for Health and Wellness (DSP #205, 291, 318, 327, 405, 438) • Person-Centered Planning (1-Day) (DSP #216, 261, 279, 291, 318, 327, 334, 341, 387, 405, 432, 435, 438, 448) • First Aid (DSP #205, 206, 230, 233, 290, 291, 318, 327, 348, 350, 354, 363, 372, 385, 388, 390, 396, 405, 406, 414, 415, 432, 449, 453) • CPR (DSP #205, 206, 230, 233, 290, 291, 318, 327, 348, 350, 354, 363, 372, 385, 388, 390, 396, 405, 406, 414, 415, 432, 449, 453) • Assisting With Medication Delivery (DSP #205, 206, 237, 281, 291, 318, 321, 327, 335, 343, 361, 363, 385, 386, 387, 390, 401, 405, 416, 425, 432, 433, 434, 437, 448, 449, 453) • Participatory Communication and Choice Making (DSP #291, 401, 405, 409, 435)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

accordance with the DDSD Medication Delivery Policy M-001. I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. **CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.** All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy; **CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:** The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:**	• Rights and Advocacy (DSP #291, 311, 401, 405, 435) • Level 1 Health (DSP #291, 311, 401, 405, 435) • Positive Behavior Supports Strategies (DSP #206, 242, 291, 401, 405, 435, 453) • Teaching and Support Strategies (DSP #200, 205, 206, 247, 291, 311, 401, 405, 409, 410, 435)		

A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.			

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;			

Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment. **CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.** All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy; **CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:** The Provider Agency must report required personnel training	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 23 of 50 Direct Support Personnel. **When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:** • DSP #402 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #39) **When DSP were asked if the individual had a Behavioral Crisis Intervention Plan and if so, what the plan covered, the following was reported:** • DSP #218 stated, "No." According to the Individual Specific Training Section of the ISP, the individual has a Behavioral Crisis Intervention Plan. (Individual #30) • DSP #269 stated, "No." According to the Individual Specific Training Section of the ISP, the individual has Behavioral Crisis Intervention Plan. (Individual #14) • DSP #278 stated, "No." According to the Individual Specific Training Section of the ISP, the individual has Behavioral Crisis Intervention Plan. (Individual #4)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training. **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and	• DSP #346 stated, "It's marked yes in the IST but it's not in here." According to the Individual Specific Training Section of the ISP, the individual has Behavioral Crisis Intervention Plan. (Individual #39) • DSP #402 stated, "No." According to the Individual Specific Training Section of the ISP, the individual has Behavioral Crisis Intervention Plan. (Individual #39) • DSP #415 stated, "No." According to the Individual Specific Training Section of the ISP, the individual has Behavioral Crisis Intervention Plan. (Individual #5) • DSP #415 stated, "No." According to the Individual Specific Training Section of the ISP, the individual has Behavioral Crisis Intervention Plan. (Individual #6) • DSP #415 stated, "No. At work she's really good." According to the Individual Specific Training Section of the ISP, the individual has Behavioral Crisis Intervention Plan. (Individual #8) **When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #203 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #34) • DSP #414 stated, "No she doesn't." According to the Individual Specific Training		

Documentation for DDSD Training Requirements. B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc.), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and	Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #7) **When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #203 stated, "Yes." According to the Individual Specific Training Section of the ISP and Agency Case File, the Individual *does not* have an Occupational Therapy Plan. (Individual #34) • DSP #203 stated, "Yes because he works." According to the Individual Specific Training Section of the ISP, the Individual *does not* have an Occupational Therapy Plan. (Individual #52) • DSP #235 stated, "She doesn't have OT." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #36) • DSP #342 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #38) **When DSP were asked if the Individual had a Physical Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #331 stated, "Not listed in file." According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #28)		

Documentation for DDSD Training Requirements. B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc.), and information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.** E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;	• DSP #346 stated, "There is no Physical Therapy Plan." According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #39) • DSP #402 stated, "Stopped about 6 months ago." According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #39) **When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:** • DSP #203 stated, "BMI and allergies." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Respiration. (Individual #52) • DSP #213 stated, "Obesity and Seizures." According to the Individual Specific Training Section of the ISP, the Individual requires Health Care Plans for Oral Hygiene. (Individual #29) • DSP #235 was unable to locate any Health Care Plans. As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Aspiration, Seizures, Bowel and Bladder, and Skin and Wound. (Individual #36) • DSP #235 was unable to locate any Health Care Plans. As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for		

	Aspiration, Seizures, Constipation, Bowel and Bladder, Respiratory, and Skin and Wound. (Individual #37) • DSP #264 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Body Mass Index. (Individual #17) • DSP #278 stated, "BMI, Constipation, Depression, Seizures, Falls." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Status of Care/Hygiene. (Individual #4) • DSP #314 stated, "Skin and Wound, Constipation, Risk for Falls, Aspiration, Seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires also requires a Health Care Plan for Body Mass Index. (Individual #51) • DSP #347 stated, "Can't think of anything they would say specifically." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Aspiration, Constipation, Bowel and Bladder and Skin and Wound. (Individual #32) • DSP #377 stated, "Falls, Aspiration, Oral Hygiene, Seizures, Constipation." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Body Mass Index and Skin and Wound. (Individual #49)		

	• DSP #401 stated, "He has no Health Care Plans. Just MERPS." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Status of Care/Hygiene, Seizures, Respiratory and Pain. (Individual #45) • DSP #402 stated, "Aspiration." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Body Mass Index. (Individual #39) • DSP #414 stated, "Aspiration, seizures, falls, bowel and bladder, constipation." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Skin and Wound. (Individual #7) • DSP #414 stated, "No just the seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Aspiration, Constipation, Bowel and Bladder and Skin and Wound. (Individual #24) • DSP #415 stated, "She's good." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Constipation. (Individual #1) • DSP #415 stated, "Aspiration, Neurology, VNS, Seizures, and Respiratory." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual		

	requires a Health Care Plan for Constipation and Skin and Wound. (Individual #6) • DSP #415 stated, "BMI. Status of Oral Car and Seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Diabetes. (Individual #8) **When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:** • DSP #203 stated, "Allergies." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Respiration. (Individual #52) • DSP #213 stated, "Seizures." According to the Individual Specific Training Section of the ISP, the Individual also requires a Medical Emergency Response Plan for Respiration. (Individual #29) • DSP #342 stated, "Bowel Obstruction and Aspiration." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Medical Emergency Response Plans for Seizures and Respiratory. When it was specifically asked if the Individual had a Seizure Medical Emergency Response Plan, DSP #342 indicated "No". (Individual #22) • DSP #347 stated, "If it's an emergency we would just call program manager and call 911." As indicated by the Electronic Comprehensive Health Assessment Tool, the		

	Individual requires a Medical Emergency Response Plan for Aspiration. (Individual #32) • DSP #401 stated, "Asthma and Seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for Pain. (Individual #45) • DSP #402 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Aspiration. (Individual #39) • DSP #414 stated, "No just the seizures as well." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Medical Emergency Response Plans for Aspiration and Constipation. (Individual #24) • DSP #415 stated, "Seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for Diabetes. (Individual #8) **When DSP were asked if the Individual had Bowel and Bladder issues and if so, what are they to monitor, the following was reported:** • DSP #415 stated, "No." As indicated by the Individual Specific Training section of the ISP Day staff are required to receive training as the Individual has bowel and bladder issues. (Individual #1)		

	• DSP #415 stated, "No." As indicated by the Individual Specific Training section of the ISP Day staff are required to receive training as the Individual has bowel and bladder issues. (Individual #5) **When DSP were asked if the Individual had a Seizure Disorder and who provided the training, the following was reported:** • DSP #296 stated, "The SLP and Service Coordinator." As indicated by the Individual Specific Training section of the ISP the nurse is required to train on seizures. (Individual #7) **When DSP were asked what the individual's Diagnosis were, the following was reported:** • DSP #407 stated, "Learning disorder is all that is there." As indicated in the ISP, the Individual is also diagnosed with High Cholesterol and Hypertension. Staff did not discuss the listed diagnosis. (Individual #47) • DSP #415 stated, "Calcium. No aspiration. No seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual is diagnosed with Impulse Control Disorder, Major Depressive Disorder, Mood Disorder, Frontal Lobe Syndrome, Mild Intellectual Disabilities, Constipation, Cortical Senile Cataract, Eczema, Hearing Loss, Hyperlipidemia, Lumbago, Nodular Goiter, Non-Inflammatory Degenerative Joint Disease, and Hypothyroidism. Staff did not discuss the listed diagnosis. (Individual #5) • DSP #415 stated, "Seizures and hearing problems." As indicated by the Electronic		

	Comprehensive Health Assessment Tool, the Individual is diagnosed with Anxiety Disorder Impulse Control Disorder, Mood Disorder, Diabetes Mellitus Type II, Hyperlipidemia, Intermittent Explosive Disorder, and Ventral Hernia. Staff did not discuss the listed diagnosis. (Individual #8) **When DSP were asked who provided the training on the Individual's Meal Time Plan, the following was reported:** • DSP #296 stated, "My Service Coordinator." As indicated by the Individual Specific Training section of the ISP, the Speech Language Pathologist will provide training on the Meal Time Plan. (Individual #7) **When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported:** • DSP #213 stated, "None that I know of." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual is allergic to Aspirin, Phenobarbital, Keflex, and Penicillin. (Individual #4) • DSP #314 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual is allergic to Iodine, Aloe and Dyes. (Individual #26) • DSP #395 stated, "Doesn't say." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual is allergic to NSAID. (Individual #56)		

	• DSP #418 stated, “Yes, Aloe Vera and Iodine.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual is also allergic to Dyes. (Individual #26) • DSP #447 stated, “No, there hasn’t been anything documented on it.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual is allergic to Iodine. (Individual #54)		

Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	Standard Level Deficiency		
NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 17 of 279 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Personnel (DSP):** • #248 – Date of hire 2/1/2011, completed 5/7/2015. • #253 – Date of hire 4/13/2015, completed 4/15/2015. • #300 – Date of hire 4/22/2015, completed 4/24/2015. • #306 – Date of hire 2/13/2015, completed 5/7/2015. • #318 – Date of hire 8/30/2014, completed 5/7/2015. • #332 – Date of hire 12/01/2008, completed 5/7/2015. • #365 – Date of hire 2/11/2015, completed 3/13/2015. • #405 – Date of hire 9/15/2008, completed 5/7/2015.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.	• #412 – Date of hire 1/16/2013, completed 3/3/2013. • #434 – Date of hire 3/2/2008, completed 5/7/2015. **Service Coordination Personnel (SC):** • #453 – Date of hire 3/31/2014, completed 8/8/2014. **Substitute Care/Respite Personnel:** • #472 – Date of hire 11/1/2007, completed 5/7/2015. • #473 – Date of hire 1/3/2011, completed 5/7/2015. • #474 – Date of hire 7/1/2007, completed 5/7/2015. • #476– Date of hire 2/5/2013, completed 5/7/2015. • #477 – Date of hire 10/21/2009, completed 5/7/2015. • #479 – Date of hire 5/2/2014, completed 3/17/2010. (*Note: Information on a break of service or position change was not provided to justify the difference in hire date and COR Date.)*		

Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer.	Based on record review and interview, the Agency did not ensure Incident Management Training for 10 of 279 Agency Personnel. **Direct Support Personnel (DSP):** • Incident Management Training (Abuse, Neglect and Exploitation) (DSP #253, 300, 302, 304, 318, 327, 391, 398, 405) **When DSP were asked to give examples of Abuse, Neglect and Exploitation, the following was reported:** • When asked to give an example of Exploitation DSP #415 stated, "It's like health issues for someone."	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

C. Incident management system training curriculum requirements: **(1)** The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to: **(a)** an overview of the potential risk of abuse, neglect, or exploitation; **(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form; **(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths; **(d)** specific instructions on how to respond to abuse, neglect, or exploitation; **(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury. **(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule. **(3)** All new employees and volunteers shall receive training prior to providing services to consumers. **D. Training documentation:** All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training			

curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.			

Tag # 1A36 Service Coordination Requirements	Standard Level Deficiency		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: K. In addition to the applicable requirements described in policy statements B – I (above), direct support staff, direct support supervisors, and internal service coordinators shall complete DDSD-approved core curriculum training. Attachments A and B to this policy identify the specific competency requirements for the following levels of core curriculum training: 1. Introductory Level – must be completed within thirty (30) days of assignment to his/her position with the agency. 2. Orientation – must be completed within ninety (90) days of assignment to his/her position with the agency. 3. Level I – must be completed within one (1) year of assignment to his/her position with the agency. **NMAC 7.26.5.7** "service coordinator": the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency **NMAC 7.26.5.11** (b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service coordinators shall assure the action plans and strategies are implemented consistent with the	Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 2 of 17 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Promoting Effective Teamwork (SC #454, 455)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

provisions of the ISP, and shall report to the case manager on ISP implementation and the individual's progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more "key" community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows: (i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations; (ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations; (iii) the designated service coordinator shall be familiar with and understand community service delivery and supports; (iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;			

Tag # 1A37 Individual Specific Training	Standard Level Deficiency		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment. **CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.** All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy; **CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:** The Provider Agency must report required personnel training	Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 4 of 271 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Personnel (DSP):** • Individual Specific Training (DSP #318, 327, 405) **Service Coordination Personnel (SC):** • Individual Specific Training (SC #460)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training. **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and			

Documentation for DDSD Training Requirements. B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc.), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and			

Documentation for DDSD Training Requirements. B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc.), and information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.** E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag # 1A03 CQI System	**Standard Level Deficiency**		
STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS d. PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met**.** The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include: i. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance; ii. The entities or individuals responsible for conducting the discovery/monitoring processes; iii. The types of information used to measure performance; and,	Based on record review and interview, the Agency had not fully implemented their Continuous Quality Management System as required by standard. Review of the Agency's CQI Plan revealed the following: • The Agency's CQI Plan did not contain the following components: a. Analysis of General Events Reports data in Therap; b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Patterns/Trends of reportable incidents; e. Results of improvement actions taken in previous quarters; f. Sufficiency of staff coverage; g. Results of General Events Reporting data analysis, Trends in category II significant events; ***(FL & SL only)*** h. Significant program changes.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

iv. The frequency with which performance is measured. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 3. Agency Requirements: J. Quality Assurance/Quality Improvement (QA/QI) Program:** Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities. 1. **Development of a QA/QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following: a. **Implementation of ISPs:** extent to which services are delivered in accordance with ISPs and associated support plans with WDSI including the type, scope, amount, duration and	i. A description of how data collected as part of the agency's QA/QI Plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QA/QI process; ***(CIES, CCS, CIHS, FL, SL, ANS)***		

frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; 3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Analysis of General Events Reports data in Therap; b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDSD training requirements; e. Patterns of reportable incidents; f. Results of improvement actions taken in previous quarters; g. Sufficiency of staff coverage; h. Effectiveness and timeliness of implementation of ISPs, and associated support including trends in achievement of individual desired outcomes; i. Results of General Events Reporting data analysis; j. Action taken regarding individual grievances; k. Presence and completeness of required documentation; **l.** A description of how data collected as part of the agency's QA/QI Plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QA/QI process; and **m.** Significant program changes.			

CHAPTER 6 (CCS) 3. Agency Requirements: I. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities. 1. **Development of a QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QI Committee:** The QA/QI committee shall convene at least quarterly and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting shall be documented. The QA/QI review should address at least the following: a. The extent to which services are delivered in accordance with ISPs, associated support plans and WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements;			

d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and g. Significant program changes. **CHAPTER 7 (CIHS) 3. Agency Requirements: G. Quality Assurance/Quality Improvement (QA/QI) Program:** Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.			

1. **Development of a QA/QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QA/QI Committee:** The QA/QI committee shall convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following: a. **Implementation of ISPs:** The extent to which services are delivered in accordance with ISPs and associated support plans and/or WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements;			

e. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise request by DOH. The report must be kept on file at the agency, made available for review by DOH and, upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs and associated support plans and/or WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; **f.** A description of how data collected as part of the agency's QA/QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and **g.** Significant program changes. **CHAPTER 11 (FL) 3. Agency Requirements: H. Quality Improvement/Quality Assurance (QA/QI) Program:** Family Living Provider			

Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities. 1. **Development of a QA/QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following: a. The extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements;			

e. Compliance with DDSD training requirements; f. Patterns in reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agency must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis, Trends in category II significant events; d. Patterns in medication errors; e. Action taken regarding individual grievances; f. Presence and completeness of required documentation; g. A description of how data collected as part of the agency's QI plan was used; h. What quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and i. Significant program changes. **CHAPTER 12 (SL) 3. Agency Requirements: B. Quality Assurance/Quality Improvement (QA/QI) Program:** Supported Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.			

1. **Development of a QA/QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following: a. Implementation of the ISP and the extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration, and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns in reportable incidents; and g. Results of improvement actions taken in previous quarters.			

2.The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH, and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis, Trends in Category II significant events; d. Patterns in medication errors; e. Action taken regarding individual grievances; f. Presence and completeness of required documentation; g. A description of how data collected as part of the agency's QA/QI plan was used, what quality improvement initiatives were undertaken, and the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and h. Significant program changes. **CHAPTER 13 (IMLS) 3. Service Requirements: F. Quality Assurance/Quality Improvement (QA/QI) Program:** Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities. 1. **Development of a QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan			

describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QA/QI Committee:** The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical Living providers, at least one nurse shall be a member of this committee. The QA meeting shall be documented. The QA review should address at least the following: a. Implementation of the ISPs, including the extent to which services are delivered in accordance with the ISPs and associated support plans and /or WDSI including the type, scope, amount, duration, and frequency specified in the ISPs as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Trends in General Events as defined by DDSD; c. Compliance with Caregivers Criminal History Screening Requirements; d. Compliance with DDSD training requirements; e. Trends in reportable incidents; and f. Results of improvement actions taken in previous quarters. 3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant			

DDSD Regional Offices. The report will summarizes: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs and associated Support plans and/or WDSI including trends in achievement of individual desired outcomes; c. Trends in reportable incidents; d. Trends in medication errors; e. Action taken regarding individual grievances; f. Presence and completeness of required documentation; g. How data collected as part of the agency's QA/QI was used, what quality improvement initiatives were undertaken, and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and h. Significant program changes. **CHAPTER 14 (ANS) 3. Service Requirements: N. Quality Assurance/Quality Improvement (QA/QI) Program:** Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities. 1. **Development of a QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and			

methods to evaluate whether implementation of improvements are working. 2. **Implementing a QA/QI Committee:** The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical Living providers, at least one nurse shall be a member of this committee. The QA meeting shall be documented. The QA review should address at least the following: a. Trends in General Events as defined by DDSD; b. Compliance with Caregivers Criminal History Screening Requirements; c. Compliance with DDSD training requirements; d. Trends in reportable incidents; and e. Results of improvement actions taken in previous quarters. 3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarizes: a. Sufficiency of staff coverage; b. Trends in reportable incidents; c. Trends in medication errors; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. How data collected as part of the agency's QA/QI was used, what quality improvement initiatives were undertaken, and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and			

g. Significant program changes **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **F. Quality assurance/quality improvement program for community-based service providers:** The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(3)** community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.			

Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **Chapter 5 (CIES) 3. Agency Requirements** **H. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. **Chapter 6 (CCS) 2. Service Requirements. E.** The agency nurse(s) for Customized Community Supports providers must provide the following services: 1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the individual's health status and medically related supports when receiving this service; **3. Agency Requirements: Consumer Records Policy:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 7 (CIHS) 3. Agency Requirements:** **E. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 11 (FL) 3. Agency Requirements:** **D. Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for	Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 7 of 55 individuals Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: • **Quarterly Nursing Review of HCP/Medical Emergency Response Plans:** ◦ None found for 5/2014 - 2/2015. (#33) ◦ None found for 3/2014 - 2/2015. (#44) • **Semi-Annual Nursing Review of HCP/Medical Emergency Response Plans:** ◦ None found for 6/2014 - 11/2014 (#1) ◦ None found for 3/2014 - 3/2015 (#10) ◦ None found for 12/2013 -11/30/2014 (#24) ◦ None found for 6/2014 - 11/2014 (#52) • **Special Health Care Needs:** • *Nutritional Evaluation* ◦ Individual #1 - As indicated by collateral documentation reviewed, evaluation was completed on 4/12/2014. Follow-up was to be completed in 1 year. No evidence of follow-up found. • *Nutritional Plan* ◦ Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

individuals are required to comply with the DDSD Individual Case File Matrix policy. **I. Health Care Requirements for Family Living: 5.** A nurse employed or contracted by the Family Living Supports provider must complete the e-CHAT, the Aspiration Risk Screening Tool,(ARST), and the Medication Administration Assessment Tool (MAAT) and any other assessments deemed appropriate on at least an annual basis for each individual served, upon significant change of clinical condition and upon return from any hospitalizations. In addition, the MAAT must be updated for any significant change of medication regime, change of route that requires delivery by licensed or certified staff, or when an individual has completed training designed to improve their skills to support self-administration. a. For newly-allocated or admitted individuals, assessments are required to be completed within three (3) business days of admission or two (2) weeks following the initial ISP meeting, whichever comes first. b. For individuals already in services, the required assessments are to be completed no more than forty-five (45) calendar days and at least fourteen (14) calendar days prior to the annual ISP meeting. c. Assessments must be updated within three (3) business days following any significant change of clinical condition and within three (3) business days following return from hospitalization. **d.** Other nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be	◦ Individual #24 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • **Health Care Plans** • *Bowel and Bladder* Individual #24 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. Individual #33 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. Individual #36 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Constipation* ◦ Individual #24 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Skin and Wound* ◦ Individual #24 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Seizures* ◦ Individual #24 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.		

documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **e.** Develop any urgently needed interim Healthcare Plans or MERPs per DDSD policy pending authorization of ongoing Adult Nursing services as indicated by health status and individual/guardian choice. **Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy:** All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **2. Service Requirements. L. Training and Requirements. 5. Health Related Documentation:** For each individual receiving Living Supports- Supported Living, the provider agency must ensure and document the following: a. That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has a MERP developed by a licensed nurse or other appropriate	• **Medical Emergency Response Plans** • *Aspiration* ◦ Individual #24 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Constipation* ◦ Individual #24 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Seizures* ◦ Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.		

professional according to the DDSD Medical Emergency Response Plan Policy, that DSP have been trained to implement such plan(s), and ensure that a copy of such plan(s) are readily available to DSP in the home; b. That an average of five (5) hours of documented nutritional counseling is available annually, if recommended by the IDT and clinically indicated; c. That the nurse has completed legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served, as well as all interactions with other healthcare providers serving the individual. All interactions must be documented whether they occur by phone or in person; and d. Document for each individual that: i. The individual has a Primary Care Provider (PCP); ii. The individual receives an annual physical examination and other examinations as specified by a PCP; iii. The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; iv. The individual receives a hearing test as specified by a licensed audiologist; v. The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and			

vi. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). vii. The agency nurse will provide the individual's team with a semi-annual nursing report that discusses the services provided and the status of the individual in the last six (6) months. This may be provided electronically or in paper format to the team no later than (2) weeks prior to the ISP and semi-annually. **f.** The Supported Living Provider Agency must ensure that activities conducted by agency nurses comply with the roles and responsibilities identified in these standards. **Chapter 13 (IMLS) 2. Service Requirements:** C. Documents to be maintained in the agency administrative office, include: A. All assessments completed by the agency nurse, including the Intensive Medical Living Eligibility Parameters tool; for e-CHAT a printed copy of the current e-CHAT summary report shall suffice; F. Annual physical exams and annual dental exams (not applicable for short term stays); G. Tri-annual vision exam (Not applicable for short term stays. See Medicaid policy 8.310.6 for allowable exceptions for more frequent vision exam); H. Audiology/hearing exam as applicable (Not applicable for short term stays; See Medicaid policy 8.324.6 for applicable requirements);			

I. All other evaluations called for in the ISP for which the Services provider is responsible to arrange; J. Medical screening, tests and lab results (for short term stays, only those which occur during the period of the stay); L. Record of medical and dental appointments, including any treatment provided (for short term stays, only those appointments that occur during the stay); O. Semi-annual ISP progress reports and MERP reviews (not applicable for short term stays); P. Quarterly nursing summary reports (not applicable for short term stays); **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. **Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010** F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:			

1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911. 5. Emergency contacts with phone numbers. 6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements…1, 2, 3, 4, 5, 6, 7, 8, **CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY**			

AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities (2) Health related plans and (4) General Nursing Documentation Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS B. IDT Coordination** (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.			

Tag # 1A27 Incident Mgt. Late and Failure to Report	Standard Level Deficiency		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **A. Duty to report:** **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer,	Based on the Incident Management Bureau's Late and Failure Reports, the Agency did not report suspected abuse, neglect, or exploitation, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 4 of 58 individuals. Individual #7 • Incident date 9/26/2014. Allegation was Neglect. Incident report was received on 9/29/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed." • Incident date 9/26/2014. Allegation was Abuse. Incident report was received on 9/29/2014. Late Reporting. IMB Late and Failure Report indicated incident of Abuse was "Unconfirmed." Individual #58 • Incident date 7/3/2014. Allegation was Neglect. Incident report was received on 7/7/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." Individual #59 • Incident date 00/00/0000. Allegation was Neglect. Incident report was received on 3/4/2015. IMB issued a Late Reporting for Neglect. Individual #60 • Incident date 00/00/0000. Allegation was Neglect. Incident report was received on	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct	3/9/2015. IMB issued a Late Reporting for Neglect.		

knowledge of the incident participates in the preparation of the report form. **(3) Limited provider investigation:** No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation. **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall: **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; **(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and **(c)** provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057. **(5) Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident. **(6) Legal guardian or parental notification:** The responsible community-			

based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative. **(7) Case manager or consultant notification by community-based service providers:** The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant. **(8) Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation			

Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency		
7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **E. Consumer and guardian orientation packet:** Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 15 of 55 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: • Parent/Guardian Incident Management Training (Abuse, Neglect and Exploitation) (#1, 2, 4, 9, 13, 21, 32, 33, 34, 35, 36, 37, 44, 47, 54)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Tag # 1A31 Client Rights/Human Rights	Standard Level Deficiency		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division**	Based on record review the Agency did not ensure the rights of Individuals was not restricted or limited for 1 of 55 Individuals. A review of Agency Individual files found no documentation of Positive Behavior Plans and/or Behavior Crisis Intervention Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (#6) No current Human Rights Approval was found for the following: • Audio Monitoring System - Last Review was dated 7/23/2014. (Individual #6) • Psychotropic Medications to control behaviors. Lorazepam (PRN) - Last Review was dated 7/23/2014. (Individual #6)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003 **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans. Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies: • Aversive Intervention Prohibitions • Psychotropic Medications Use • Behavioral Support Service Provision. A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up. **A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS** Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval. 2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly. 3. Records, including minutes of all meetings will be retained at the agency with primary			

responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:** **Medication Assessment and Delivery** **Procedure Eff Date: November 1, 2006** **B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).			

Tag # 1A33 Board of Pharmacy – Med. Storage	Standard Level Deficiency		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **E. Medication Storage:** 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. **8. References** A. Adequate drug references shall be available for facility staff **H. Controlled Substances (Perpetual Count Requirement)** 1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance,	Based on observation, the Agency did not to ensure proper storage of medication for 2 of 24 individuals. Observation included: Individual #14 Personal Lubricating Jelly: expired 4/2015. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. Individual #34 Loperamide 1mg: expired 1/2015. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. Carbamide Peroxide 6.5% (Ear Drops): expired 4/17/2015. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

indicating the following information: a. date b. time administered c. name of patient d. dose e. practitioner's name f. signature of person administering or assisting with the administration the dose g. balance of controlled substance remaining.			

Tag # 1A33.1 Board of Pharmacy - License	Standard Level Deficiency		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **6. Display of License and Inspection Reports** A. The following are required to be publicly displayed: ☐ Current Custodial Drug Permit from the NM Board of Pharmacy ☐ Current registration from the consultant pharmacist ☐ Current NM Board of Pharmacy Inspection Report	Based on observation, the Agency did not provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 1 of 19 residences: Individual Residence: • Current Custodial Drug Permit from the NM Board of Pharmacy (#3) *(Note: A 2nd DDW Individual additionally lived in the home who was non-related)*	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Tag # LS13 / 6L13 Community Living Healthcare Reqts.	Standard Level Deficiency		
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy:** All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007	Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 7 of 20 individuals receiving Community Living Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: • ***Dental Exam*** ◦ Individual #3 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #11 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #17 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #48 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • ***Vision Exam*** ◦ Individual #38 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community	◦ Individual #45 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #48 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. • ***Podiatry Exam*** ◦ Individual #14 - As indicated by collateral documentation reviewed, exam was scheduled for 4/8/2015. No evidence of exam results were found.		

Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).			

Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 11 (FL) Living Supports – Family Living Agency Requirements G. Residence Requirements for Living Supports- Family Living Services:** 1.Family Living Services providers must assure that each individual's residence is maintained to be clean, safe and comfortable and accommodates the individuals' daily living, social and leisure activities. In addition the residence must: j. Maintain basic utilities, i.e., gas, power, water and telephone; k. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; l. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system; m. Have a general-purpose first aid kit; n. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; o. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year; p. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 11 of 19 Supported Living and Family Living residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Water temperature in home does not exceed safe temperature (110^0 F) ➢ Water temperature in home measured 116^0 F (#6) ➢ Water temperature in home measured 131.8^0 F (#14) ➢ Water temperature in home measured 114.8^0 F (#18) ➢ Water temperature in home measured 116^0 F (#42) ➢ Water temperature in home measured 124^0 F (#49) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#26, 42) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

consistent with the Assisting with Medication Delivery training or each individual's ISP; and q. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. **CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports-Supported Living Services:** 1. Supported Living Provider Agencies must assure that each individual's residence is maintained to be clean, safe, and comfortable and accommodates the individual's daily living, social, and leisure activities. In addition the residence must: f. Maintain basic utilities, i.e., gas, power, water, and telephone; g. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; h. Ensure water temperature in home does not exceed safe temperature (110^0 F) ; i. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system; j. Have a general-purpose First Aid kit;	emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#7, 18, 26, 37, 38, 42, 49) *Note: The following Individuals share a residence:* ➢ #7, 37 **Family Living Requirements:** • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#48) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#29, 50)		

k. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; l. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills must occur at least once a year during each shift; m. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and n. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. **CHAPTER 13 (IMLS) 2. Service Requirements R. Staff Qualifications: 3. Supervisor Qualifications And Requirements:** S Each residence shall include operable safety equipment, including but not limited to, an operable smoke detector or sprinkler system, a carbon monoxide detector if any natural gas appliance or heating is used, fire extinguisher, general purpose first aid kit, written procedures for emergency evacuation due to fire or other emergency and documentation of evacuation drills occurring at least annually during each shift, phone number for poison control within line of site of the telephone, basic utilities, general household appliances, kitchen and dining utensils, adequate food and drink for			

three meals per day, proper food storage, and cleaning supplies. T Each residence shall have a blood borne pathogens kit as applicable to the residents' health status, personal protection equipment, and any ordered or required medical supplies shall also be available in the home. U If not medically contraindicated, and with mutual consent, up to two (2) individuals may share a single bedroom. Each individual shall have their own bed. All bedrooms shall have doors that may be closed for privacy. Individuals have the right to decorate their bedroom in a style of their choosing consistent with safe and sanitary living conditions. V For residences with more than two (2) residents, there shall be at least two (2) bathrooms. Toilets, tubs/showers used by the individuals shall provide for privacy and be designed or adapted for the safe provision of personal care. Water temperature shall be maintained at a safe level to prevent injury and ensure comfort and shall not exceed one hundred ten (110) degrees. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services**			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag # IS25 / 5I25 Community Integrated Employment Services / Supported Employment Reimbursement	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 6. REIMBURSEMENT:** A. All Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. 1. The documentation of the billable time spent with an individual must be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record must contain the following: a. Date, start, and end time of each service encounter or other billable service interval; b. A description of what occurred during the encounter or service interval; and c. The signature or authenticated name of staff providing the service. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 8 of 28 individuals Individual #4 February 2015 • The Agency billed 25 units of Supported Employment (T2019 HB HQ) on 2/19/2015. Documentation received accounted for 24 units. March 2015 • The Agency billed 23 units of Supported Employment (T2019 HB HQ) on 3/31/2015. No documentation found to support billing on 03/31/2015. Individual #5 February 2015 • The Agency billed 18 units of Supported Employment (T2019 HB HQ) on 2/17/2015. Documentation received accounted for 16 units. • The Agency billed 25 units of Supported Employment (T2019 HB HQ) on 2/18/2015. No documentation found to support billing on 2/18/2015. Individual #10	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.	February 2015 • The Agency billed 30 units of Supported Employment (T2019 HB HQ) on 2/10/2015. Documentation received accounted for 28 units. Individual #16 January 2015 • The Agency billed 22 units of Supported Employment (T2019 HB HQ) on 1/6/2015. No documentation found to support billing on 1/6/2015, • The Agency billed 25 units of Supported Employment (T2019 HB HQ) on 1/8/2015. No documentation found to support billing on 1/8/2015. • The Agency billed 23 units of Supported Employment (T2019 HB HQ) on 1/13/2015. No documentation found to support billing on 1/13/2015. • The Agency billed 24 units of Supported Employment (T2019 HB HQ) on 1/15/2015. No documentation found to support billing on 1/15/2015. • The Agency billed 26 units of Supported Employment (T2019 HB HQ) on 1/20/2015. No documentation found to support billing on 1/20/2015. • The Agency billed 24 units of Supported Employment (T2019 HB HQ) on 1/22/2015. No documentation found to support billing on 1/22/2015.		

	• The Agency billed 17 units of Supported Employment (T2019 HB HQ) on 1/27/2015. No documentation found to support billing on 1/27/2015. • The Agency billed 25 units of Supported Employment (T2019 HB HQ) on 1/29/2015. No documentation found to support billing on 1/29/2015. February 2015 • The Agency billed 24 units of Supported Employment (T2019 HB HQ) on 2/5/2015. No documentation found to support billing on 2/5/2015. • The Agency billed 21 units of Supported Employment (T2019 HB HQ) on 2/10/2015. No documentation found to support billing on 2/10/2015. • The Agency billed 24 units of Supported Employment (T2019 HB HQ) on 2/12/2015. No documentation found to support billing on 2/12/2015. • The Agency billed 24 units of Supported Employment (T2019 HB HQ) on 2/17/2015. No documentation found to support billing on 2/17/2015. • The Agency billed 17 units of Supported Employment (T2019 HB HQ) on 2/19/2015. No documentation found to support billing on 2/19/2015. • The Agency billed 22 units of Supported Employment (T2019 HB HQ) on 2/24/2015.		

	No documentation found to support billing on 2/24/2015. • The Agency billed 26 units of Supported Employment (T2019 HB HQ) on 2/26/2015. No documentation found to support billing on 2/26/2015. March 2015 • The Agency billed 26 units of Supported Employment (T2019 HB HQ) on 3/3/2015. No documentation found to support billing on 3/3/2015. • The Agency billed 25 units of Supported Employment (T2019 HB HQ) on 3/5/2015. No documentation found to support billing on 3/5/2015. • The Agency billed 30 units of Supported Employment (T2019 HB HQ) on 3/10/2015. No documentation found to support billing on 3/10/2015. • The Agency billed 13 units of Supported Employment (T2019 HB HQ) on 3/12/2015. No documentation found to support billing on 3/12/2015. • The Agency billed 22 units of Supported Employment (T2019 HB HQ) on 3/17/2015. No documentation found to support billing on 3/17/2015. • The Agency billed 22 units of Supported Employment (T2019 HB HQ) on 3/19/2015. No documentation found to support billing on 3/19/2015.		

	• The Agency billed 22 units of Supported Employment (T2019 HB HQ) on 3/24/2015. No documentation found to support billing on 3/24/2015. • The Agency billed 23 units of Supported Employment (T2019 HB HQ) on 3/26/2015. No documentation found to support billing on 3/26/2015. • The Agency billed 23 units of Supported Employment (T2019 HB HQ) on 3/31/2015. No documentation found to support billing on 3/31/2015. Individual #39 February 2015 • The Agency billed 25 units of Supported Employment (T2019 HB HQ) on 2/5/2015. Documentation did not contain the required elements on 2/5. Documentation received accounted for 0 units. One or more of the required elements was not met: ➢ End time of each service encounter or other billable service interval; Individual #44 March 2015 • The Agency billed 6.25 units of Supported Employment (T2013 U3) on 3/13/2015. No documentation found to support billing on 3/13/2015. Individual #55 March 2015 • The Agency billed 28 units of Supported Employment (T2019 HB HQ) on 3/3/2015. Documentation received accounted for 26 units.		

	Individual #56 January 2015 • The Agency billed 34 units of Supported Employment (T2019 HB HQ) on 1/3/2015. No documentation found to support billing on 1/3/2015. • The Agency billed 34 units of Supported Employment (T2019 HB HQ) on 1/8/2015. No documentation found to support billing on 1/8/2015. • The Agency billed 34 units of Supported Employment (T2019 HB HQ) on 1/21/2015. No documentation found to support billing on 1/21/2015. February 2015 • The Agency billed 34 units of Supported Employment (T2019 HB HQ) on 2/12/2015. No documentation found to support billing on 2/12/2015. • The Agency billed 34 units of Supported Employment (T2019 HB HQ) on 2/14/2015. No documentation found to support billing on 2/14/2015.		

Tag # 5I44 Adult Habilitation Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 2 of 12 individuals. Individual #7 March 2015 • The Agency billed 30 units of Adult Habilitation (T2021 U1) on 3/18/2015. Documentation received accounted for 23 units. Individual #38 February 2015 • The Agency billed 25 units of Adult Habilitation (T2021 U1) on 2/10/2015. Documentation received accounted for 20 units.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours. (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours			

Tag # IS30 Customized Community Supports Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 6 (CCS) 4. REIMBURSEMENT A. Required Records:** All Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, nature of services, and length of a session of service billed. 1. The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record shall contain the following: a. Date, start and end time of each service encounter or other billable service interval; b. A description of what occurred during the encounter or service interval; and c. The signature or authenticated name of staff providing the service. B. **Billable Unit:** 1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 1 of 29 individuals. Individual #9 January 2015 • The Agency billed 23 units of Customized Community Supports (T2021 HB U8) on 1/27/2015. Documentation received accounted for 22 units.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit. 3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group. 4. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDSD. 5. The billable unit for Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit. (There is a separate rate established for individuals who require one-to-one (1:1) support either in the community or in a group day setting due to behavioral challenges (NM DDW group G). 6. The billable unit for Fiscal Management for Adult Education is dollars charged for each class including a 10% administrative processing fee. C. **Billable Activities:** 1. All DSP activities that are: a. Provided face to face with the individual; b. Described in the individual's approved ISP; c. Provided in accordance with the Scope of Services; and d. Activities included in billable services, activities or situations.			

2. Purchase of tuition, fees, and/or related materials associated with adult education opportunities as related to the ISP Action Plan and Outcomes, not to exceed $550 including administrative processing fee. 3. Customized Community Supports can be included in ISP and budget with any other services. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.			

Tag # IH32 Customized In-Home Supports Reimbursement	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 7 (CIHS) 4. REIMBURSEMENT. A.** All Provider Agencies must maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the individual's name, date, time, Provider Agency name, nature of services and length of a session of service billed. 4. The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record shall contain the following: a. Date, start and end time of each service encounter or other billable service interval; b. A description of what occurred during the encounter or service interval; and c. The signature or authenticated name of staff providing the service. 5. Customized In-Home Supports has two different rates which are based on the individual's living condition (i.e., Living with Natural Supports or Living Independently). The maximum allowable billable hours cannot exceed the budget allocation in the associated service packages.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized In-Home Supports Reimbursement for 1 of 7 individuals. Individual #47 March 2015 • The Agency billed 22 units of Customized In-Home Supports (S5125 HB) on 3/23/2015. No documentation found to support billing on 3/23/2015.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

B. Billable Units: The billable unit for Customized In-Home Support is based on a fifteen (15) minute unit. **C. Billable Activities:** 1. Direct care provided to an individual in the individual's residence, consistent with the Scope of Services, any portion of the day. 2. Direct support provided to an individual consistent with the Scope of Services by Customized In-Home Supports direct support personnel in community locations other than the individual's residence.			

Date: September 10, 2015

To: Mike Kivitz, Chief Executive Officer

Provider: Adelante Development Center
Address: 3900 Osuna Rd. NE
State/Zip: Albuquerque, New Mexico 87109

E-mail Address: mkivitz@goadelante.org

CC: Jim Bullard, Vice President
E-Mail Address jbullard@goadelante.org

CC: Phil Blackshear, QAO
E-Mail Address pblackshear@goadelante.org

Region: Metro
Survey Date: May 4 – 13, 2015
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Living Supports* (Supported Living and Family Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living, Family Living, Independent Living) and *Community Inclusion* (Adult Habilitation, Supported Employment)

Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Mr. Kivitz, Mr. Blackshear and Mr. Bullard,

Your request for a Reconsideration of Findings was received on September 3, 2015. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A26
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on review of the survey tools and documentation provided during the IRF process, citations for the following Direct Support Personnel (DSP) will be removed: DSP #472, 248, 300, 365, 412, 479, 476 and 477. DSP #458 was mentioned in the Request for an IRF but was not found to be cited in this Tag. Evidence provided was not sufficient to support the removal of DSP #253, 306, 318, 473 and 474. For these individuals evidence of a clearance not the Consolidated On-line

Registry Check was provided and/or documentation provided did not show that the Consolidated On-line Registry Check was completed prior to hire. The remaining citations noted in this tag were not disputed.

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.
Respectfully,

Crystal Lopez-Beck

Crystal Lopez-Beck
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

Q.15.4.DDW.D0009.5.RTN.12.15.253

Date: January 13, 2016

To: Mike Kivitz, Chief Executive Officer

Provider: Adelante Development Center
Address: 3900 Osuna Rd. NE
State/Zip: Albuquerque, New Mexico 87109

E-mail Address: mkivitz@goadelante.org

CC: Jim Bullard, Vice President
E-Mail Address jbullard@goadelante.org

CC: Phil Blackshear, QAO
E-Mail Address pblackshear@goadelante.org

Region: Metro
Survey Date: May 4 – 13, 2015
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Living Supports* (Supported Living and Family Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living, Family Living, Independent Living) and *Community Inclusion* (Adult Habilitation, Supported Employment)

Survey Type: Routine

Dear Mr. Kivitz;

The Division of Health Improvement Quality Management Bureau received and reviewed the documents you submitted for your Plan of Correction. Your Plan of Correction is not closed.

Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.

The Quality Management Bureau will be need to conduct a verification survey to ensure previously cited deficiencies have been corrected and that systemic Quality Improvement and Quality Assurance processes have been effective at sustaining corrections.

If the Verification survey determines survey deficiencies have been corrected and corrective measures have effectively maintained compliance with DDW Standards, your Plan of Correction will be considered for closure.

If the Verification survey identifies repeat deficiencies, the Plan of Correction process will continue and your case may be referred to the Internal Review Committee for discussion of possible civil monetary penalties possible monetary fines and/or other sanctions.

Thank you for your cooperation with the Plan of Correction process.
Sincerely,

Amanda Castañeda

Amanda Castañeda
Health Program Manager/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.15.4.DDW.D0009.5.RTN.07.15.13